NYC Health Department | Public Schools

Fòm pou bay medikaman kont dyabèt
Adendom jeneral DMAF | Ane Lekòl 2026-2027
Tanpri fakse tout DMAF nan 347-396-8932/8945 oswa imèl OSHDMAF@health.nyc.gov

Siyati **elèv** la	Non elèv la	Dat nesans li	Sèks ☐ Gason ☐ Fi	# OSIS:
Non/ATSDBN **lekòl** la	Adrès	Borough	Distri	Nivo klas/salklas

This is an optional form for small changes to a diabetes regimen during the school year. Please see 'Provider Guidelines for DMAF Completion' for more details.

Change Student Skill Level:

Glucose Monitoring:	**Insulin Dosing & Administration:**		
☐ Nurse-Dependent ☐ Supervised ☐ Independent	☐ Nurse-Dependent ☐ Supervised ☐ Independent*	_____ (Provider Initials)	*** I attest that the independent student** demonstrated ability to self-carry & self-administer the prescribed medication (excluding glucagon) effectively during school, field trips, and school sponsored events.

Change Blood Glucose (bG)/Sensor Glucose (sG) Monitoring Times:
☐ PRN ☐ Breakfast ☐ Lunch ☐ Snack ☐ Gym ☐ Dismissal
☐ Discontinue all bG/sG monitoring at school, including PRN instructions

Change CGM Brand/Model: Name: _____ ☐ Use attached CGM grid
**If starting a CGM for the first time, please submit an updated DMAF.*

Change Insulin Dosing:
☐ Discontinue all rapid-acting insulin in school, including instructions to give correction doses PRN or in the setting of ketosis

Change target blood glucose to:

____ mg/dl from _____ AM/PM to _____ AM/PM

____ mg/dl from _____ AM/PM to _____ AM/PM

Change insulin sensitivity factor (ISF) to:

1: ____ mg/dl from _____ AM/PM to _____ AM/PM

1: ____ mg/dl from _____ AM/PM to _____ AM/PM

Change insulin to carbohydrate ratio (I:C) to:

1: ____ g from ____ AM/PM until _____ AM/PM or at ☐ Breakfast ☐ Lunch ☐ Snack

1: ____ g from ____ AM/PM until _____ AM/PM or at ☐ Breakfast ☐ Lunch ☐ Snack

Change long-acting insulin at school: Name: _____ Dose: ____ units Time: _____ ***OR*** pre-lunch

Other Orders

By signing this form, I certify that I have discussed these orders with the parent(s)/guardian(s).				
Health Care Provider Last Name (PLEASE PRINT)	First name	**Signature**		**Date**
Credentials: ☐ MD ☐ DO ☐ NP ☐ PA				
Address Street	City/State	ZIP	**Email**	
NYS License # or NPI # (Required)	Tel	Fax	CDC & AAP recommend annual seasonal influenza vaccination for all children diagnosed with diabetes.	